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Article

Building culturally sensitive substance use prevention and treatment programs for transgendered populations

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Abstract

Studies show that transgendered individuals are at high risk for substance use problems. It is important to identify the unique needs and concerns of these individuals and culturally sensitive programs that will be successful in recruiting and retaining these individuals in drug abuse treatment services. This involves incorporating the needs of services from the perspectives of both the transgendered community and health-care professionals. It is the purpose of this article to discuss transgenderism as well as the substance use problems and difficulties within substance use treatment that transgendered men and women may face. This article presents guidelines for the design and evaluation of health-care services to transgendered populations.

Keywords: Transgender; Drug treatment; Alcohol treatment

1. Introduction

Culturally sensitive programs are being seen as an effective way to structure substance use programs. Programs designed to handle issues specific to people's race/ethnicity, gender, age, and/or sexual orientation are seen to be an effective way in helping people recover from addiction and to prevent HIV infection (Grella et al., 1996; Jackson et al., 1997; John et al., 1997; Ratner, 1993; Ruiz & Langrod, 1997; Travers & Schneider 1996; Wallen, 1998; Westermeyer, 1997). Not only is it seen to be more effective in helping them, but it could also be more cost-effective in the long run to design programs that will be accepted and utilized by participants. Unfortunately, few, if any, substance use treatment programs contain provisions for transgendered individuals, therefore, these individuals may be difficult to reach with traditional campaigns and may fear discrimination should they seek services (Bockting et al., 1998; Clements et al., 1999). Insensitivity and discrimination on the part of health-care professionals has been offered as reasons why services are not accessed. Indeed, reports of maltreatment by health-care providers suggest that services are severely lacking in culturally sensitive interventions. It is the purpose of this article to examine several potential deficits in care to these individuals and to discuss specific guidelines for the design of more effective prevention and treatment services for transgendered individuals. Such guidelines should result in services that are more likely to be accessed, and retain the client in treatment.

Transgender refers to the population of individuals who do not conform to traditional conceptions of sex and gender.[1] Transgendered individuals can vary widely in their gender identity and presentation. In the transgendered population, those who were assigned male at birth may identify as women (male to female, or transsexual women) and those who were assigned female at birth may identify as men (female to male, or transsexual men). Different cultures also have different ways of ascribing roles and labels and vary in the ways they explain and incorporate gender variance. Frequently, personal access to resources (e.g., information, education, monetary, social networks, and emotional strength) can play a role in whether and to what degree one identifies and presents publicly as transgender. Regardless, there is a wide range of potential presentations.

The incidence of transsexualism, based on studies outside the United States and using different measures of prev-

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[1]It should be noted that this does not refer to how people self-identify, but is merely a shorthand term to be used to identify collectively crossdressers, transsexuals, travestis, hidjras, etc. The case is that there are a variety of self-identifications that should be used when referring to specific individuals or groups of people. The term *transgender* is used here to refer to individuals or groups of people who are themselves diverse in self-definition but generally do not conform to society's conception of sex and gender roles.

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alence, is approximately 1 per 20,000 to 50,000 persons, with there being more transsexual women (male to female) than transsexual men (female to male) (Weitze & Osburg, 1996). Prevalence rates have been shown to vary across countries. Bakker et al. (1993) reported the prevalence of transsexualism among persons native to the Netherlands by counting the number of persons seen by psychiatrists and psychologists who were subsequently hormonally treated and underwent sex reassignment therapy. They found that the prevalence rate for transsexual individuals to be 1:11,900 transsexual women, compared to 1:30,400 transsexual men; a ratio of 2.5 transsexual women to 1 transsexual man. In Sweden, transsexuality has been reported to be found equally in transsexual women and transsexual men (Landeb et al., 1996). However, the prevalence of transsexualism may be underestimated. Most studies tend to utilize people sampled from gender clinics and mental health settings, which may underrepresent the prevalence as many individuals do not (or cannot) access such services. Within some literature, transgenderism is ambiguously conceptualized, lending to the confusion about prevalence. Transgenderism is confused with sexual orientation, for example, transgender/transsexual women are believed to be gay or bisexual men or as men who have sex with men (MSM). What may be the case is that their sexual orientation is heterosexual rather than gay or bisexual. Transgendered individuals' sexual orientation can vary widely; thus, to correctly identify an individual's sexual orientation one must be careful to ask the client without prejudging their gender identity or sexual orientation.

Still another problem occurs when we assume that transgendered individuals are only women, that is, they were assigned male at birth and later identify and/or present themselves as women. As previously noted, there are those who were assigned female at birth and later identify and/or present themselves as men (female to male or transgendered men). While there has been ample attention to transgendered women few studies have examined transgendered men in regard to their behaviors and any associated health risks they may endure. Transgendered men and women should not be seen as similar counterparts for they are distinctive in regard to physical, psychological, and social experiences. Transgendered individuals can also vary by race/ethnicity, class, gender, sexual orientation, and a host of other characteristics, which make them unique and difficult to group. In short, they should not be seen as a homogeneous group of people, and their differences need to be taken into account by health-care providers.

2. Violence and discrimination provoking substance use

It is important that health-care providers understand the social dilemmas facing these individuals in order to provide culturally sensitive prevention and treatment programs. Transgendered individuals are likely to experience some form of discrimination and/or violence sometime in their lives. A study of transgendered individuals within the United States found that approximately 60% experienced some form of harassment and/or violence sometime within their life and 37% experienced some form of economic discrimination (Lombardi et al., 1998). Violence and discrimination have been found to have negative effects upon other populations. Garnets et al. (1992) stated that experiences of violence and harassment can significantly affect the mental health of gay men and lesbians, which in turn could influence their substance use as well as their experience within treatment programs. Experiences of violence and harassment could similarly affect transgendered individuals. A study of transgendered individuals participating in focus group discussions in San Francisco found that a lack of educational and job opportunities, and low self-esteem contributed to drug and alcohol abuse (San Francisco Department of Public Health, AIDS Office, 1997). It is also likely that transgendered youth will have a greater need for services and support.

3. Transgendered youth

Researchers are finding that social and psychological problems can place youth at risk for drug abuse, and there are calls for youth-specific strategies of reducing substance use within adolescents. Unfortunately, transgendered youth generally have few resources to draw upon (Kreiss & Patterson, 1997). Within the educational system, transgendered individuals face discrimination and outright dismissal. In one case, a transgendered teacher was forced to quit because of pressure from parents and conservative groups, and in another case a male-to-female transgendered youth was expelled because she chose to present herself as a girl in school (Bentley & Levy, 1999; Sewell, 1998). The result of these discriminatory actions is a social climate in which transgendered youth are marginalized and robbed of social role models. Many times these teens then run away or are thrown out of their homes and families, resulting in many of the problems faced by homeless/runaway youth, however, with the added problem of being transgender within a hostile society. Savin-Williams (1994) stated that verbal and physical abuse could influence the substance use (and prostitution and suicide) of gay, lesbian, and bisexual youth. He also stated that "cross-gendered" youths are most likely to be abused because they do not meet the cultural ideals of gender-appropriate behaviors and roles. As such, these transgendered youth are at a very high risk of substance use-related problems (Kreiss & Patterson, 1997; Rodgers, 1995).

While substance abuse treatment programs could significantly improve their lives as well as reduce their risk of HIV infection, keeping these individuals in treatment programs has been reported to be problematic. Health-care service providers have found that getting transgendered individuals the services they need (e.g., substance use treatment, housing, and health care) is difficult because of discrimination.

Further, the level of sensitivity on the part of providers can influence whether transgendered individuals will access and stay in treatment (Clements et al., 1999; Moriarty et al., 1998; The Transgender Substance Abuse Treatment Policy Group of the San Francisco Lesbian, Gay, Bisexual, and Transgender Substance Abuse Task Force, 1995). Many transgendered individuals are resistant to seek help because other transgendered individuals reported past discrimination by service providers.

Reback and Lombardi (1999) reported that alcohol, cocaine/crack, and methamphetamines were the most common drugs used by the transgendered women in their study (no studies have examined substances used by transgendered men). However, traditional substances of abuse are not the only potential health risks faced by transgendered individuals. Injectable hormones and silicone can pose problems for transgendered individuals in much the same way steroid use can (Schwerin et al., 1996; Wroblewska, 1997). Transgendered individuals use hormones to change their appearance so that it corresponds with their identity. Individuals may have their hormones prescribed to them by a physician, but this requires them to have access to health care and be able to afford the treatment (either out of pocket or through health insurance). Current recommendations require transgendered individuals to undergo psychological counseling before pursuing stages of sex-reassignment therapy. Many transgendered individuals find this to be too restrictive and psychologically invasive as they feel they do not feel distressed and do not feel that their gender identity warrants the need to see a therapist of any type. Further, poverty may be another reason for not allowing people access to medical care that Harry Benjamin Standards requires (3 months psychotherapy) in order to begin taking hormones (Levine et al., 1998). Other problems, including the belief that one's doctor is not prescribing a high enough dosage or that health-care providers are not sensitive to their needs, influence the satisfaction of transgendered persons and whether they will return for treatment. Because of these factors, many transgendered individuals purchase hormones from other underground sources and administer them to each other or to themselves. These hormones may be injectable and have the same HIV risks as other injectable drugs. Transgendered women may also inject silicone or oils (mineral and vegetable) into their bodies in order to change their appearance, and may be associated with HIV infection (Goihman et al., 1994; Inciardi & Surratt, 1997). Studies have reported ill health effects associated with silicone and oil injections in nontransgendered populations (Chen, 1995; Rapaport et al., 1996; Rollins et al., 1997).

4. Substance use treatment

Ratner (1993) points out that treating chemically dependent gays and lesbian clients requires being aware of their unique problems in order for treatment to be effective. Factors such as homophobia (both internal and societal), violence, family issues, and isolation among other problems need to be addressed within the treatment environment. Israelstam (1986) found that many treatment programs did not have policies or programs in place to help gay and lesbian substance users. The same could be said currently for transgendered substance users. Focus groups in San Francisco and Minneapolis also found evidence discrimination within HIV/AIDS and substance use programs (Bockting et al., 1998; San Francisco Department of Public Health, AIDS Office, 1997). Many substance abuse programs are not sensitive to the needs of transgendered individuals, are not transgender-specific to deal with the realities that many transgendered people face (Bockting et al., 1998; San Francisco Department of Public Health, AIDS Office, 1997). The Transgender Substance Abuse Treatment Policy Group of the San Francisco Lesbian, Gay, Bisexual, and Transgender Substance Abuse Task Force (1995) reported that transgendered clients of substance abuse treatment programs have experienced:

1. Verbal and physical abuse by other clients and staff;
2. Being required to wear only clothes judged to be appropriate for their biological gender; and
3. Being required to shower and sleep in areas judged to be appropriate for their biological gender.

Anecdotal statements from individuals who work with transgendered clients in Los Angeles generally report similar findings. An important consideration in the housing of transgendered women is based on the finding of Stephens et al. (1999) who found that transgendered women incarcerated with men were more likely to be involved in sexual activity in prison compared to nontransgendered inmates (men). They conclude that transgendered women in prison are in need of specific social support and preventative materials in addition to protection from assault (including sexual assault).

These negative experiences confronting transgendered individuals, could and most likely have had negative affects on their course of recovery. Overall, transgendered individuals have to face many hurdles with little or no support. In short, transgendered individuals must navigate through a health-care system that is unable to comprehend let alone support transgendered individuals. As such, their substance use problems and other health-care concerns may not be treated effectively.

5. Improving care for transgendered individuals

Recognizing the perils that transgendered men and women face in health care and behavioral health and drug abuse treatment programs in the United States, efforts have been made to create guidelines that may facilitate the care and treatment of transgendered individuals. Green and Brinkin (1994) and The Transgender Substance Abuse Treatment Policy Group of the San Francisco Lesbian, Gay, Bisexual, and Transgender Task Force (1995) have pre-

sented guidelines, in regards to cultural sensitivity and program design, for the treatment of transgendered individuals.

5.1. Cultural sensitivity issues

1. Acknowledge that transgendered individuals can vary across many different social categories including sexual orientation.
2. Allow transgendered individuals to define their own gender rather than impose and identity upon them.
3. Acknowledge that the current social climate places transgendered individuals at risk for discrimination and violence within many public and private social contexts.
4. State the need for sensitivity training for all governmental agencies.
5. Categorizing transgendered men and women as such and not conflate them with gay men or lesbians (unless as appropriate to an individual's sexual orientation in their preferred gender) as well as to acknowledge the variation that exists between transgendered individuals.
6. Treating transgendered individuals with dignity and respect. This includes referring to them as the gender with which they identify.

5.2. Program design issues

1. Add transgender/gender identity to antidiscrimination policies.
2. Protect transgendered individuals by not forcing them to disclose their transgender status.
3. Do not impose arbitrary dress codes where they are not necessary. Where there is a reasonable requirement for a dress code, then reasonable accommodations should be made so that transgendered individuals' dignity and privacy are preserved along with the concerns of others.
4. Do not restrict transgendered individuals' access to public restroom facilities that are appropriate to a person's gender identity or some other reasonable accommodation.
5. Therapy and related programs must address the following issues:
   - 5.1. Self-esteem issues related to how they look and how they feel about themselves;
   - 5.2. Dealing with one's family and one's own level of self-acceptance;
   - 5.3. Changing one's gender on the job, finding and changing jobs;
   - 5.4. Experiencing discrimination and/or violence against them;
   - 5.5. Safe and supportive medical care, including safe access to hormones, and sex reassignment surgery if they so desire;
   - 5.6. That transgendered individuals be housed in a manner consistent with the guidelines of each individual program based upon their gender self-identity, or some other reasonable accommodation. They should be asked what kind of accommodations would make them feel safe;
   - 5.7. That HIV/AIDS programs address the realities of transgender bodies as well as the issues related to transgender participation within sex work.
6. Transgender youth programs need to be developed in which:
   - 6.1. Issues relating to identity and sexuality are discussed in a manner that incorporates transgender issues. Issues relating to one's body should also be included.
   - 6.2. They have help in going through the legal and medical procedures that are required in establishing one's social gender.
   - 6.3. Educational support services are offered to prevent youth from dropping out of school.
   - 6.4. Peer groups and role models are fostered so that they can support transgendered youth.

5.3. The role of hormones

The difficulty in which many transgendered individuals may experience having hormones legally prescribed to them may drive people to obtain hormones illicitly, and the networks involved with illicit hormone use may overlap with illicit drugs and HIV risk behavior. This could have implications on people's recovery as well as whether they are exposed to and initiate other illicit drug use. Adolescents who are beginning to change their gender and do not have ready access to hormones may seek to purchase them illicitly, and in doing so become unnecessarily exposed to a larger illicit drug network and may begin using other substances. In terms of relapse prevention, transgendered individuals within treatment settings will need another source of hormones to prevent them from going back out and purchasing them from illicit sources, and in doing so placing them at risk for relapse. This raises the issue of whether substance use treatment and prevention strategies should also include administering hormones to transgendered individuals so that they are not exposed to contexts that may cause them to begin using or to resume using illicit drugs. Grimaldi and Jacobs (1998) have reported that this approach is an effective strategy to increase the participation and engagement of transsexual women within their HIV program.

The purpose behind these guidelines is to correct recognized deficiencies within substance use programs. Because of transgendered men and women's likelihood of encountering negative health care and substance abuse treatment experiences it is critical that programs extend a concerted effort to achieve a higher level of cultural sensitivity with respect to caring for transgendered populations. While it is more likely that health care and substance use treatment programs in large HIV epicenters like Los Angeles, San Francisco, and New York will take heed of these recom-

mendations, other large cities and even smaller rural communities need to be alerted to the deficiencies in care to transgendered populations. It is still possible that transgendered individuals will need to seek services outside of large cities, and for whatever reasons, their transgender status will become known to health-care providers. As such, these guidelines are applicable to them as well. It is hoped that this discussion and the guidelines developed will enhance health-care providers' ability to treat the health problems of transgendered individuals with greater compassion and understanding.

In summary, there is an urgent need for the provision of culturally sensitive health care for transgendered individuals, not just at the level of prevention but at the level of treatment as well. Beginning efforts to establish individualized special care clinics for the treatment of transgendered individuals exists in some large cities (e.g., Los Angeles and San Francisco). Just as special care units and clinics for gay, lesbian, and bisexual clients have been successful in presenting models for practice, these programs should provide guidance to others in constructing effective and culturally sensitive services. Training of health-care professionals in the unique needs and concerns of this population is warranted. Additionally, since discrimination can also affect other communities by race, ethnicity, and social status, specific attention should be given to communities of color, where risks may be even higher. Awareness and attention to the unique concerns of these groups may result in significant improvements in providers' ability to recruit and successfully treat these individuals.

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